## APPENDIX 1a AMBULANCE - EMERGENCY, ONE ROUND TRIP WITH NONEMERGENCY RETURN DESTINATION

			W	TH NO	NE.	MERGEN		ETURN DE									
			HEALTH INSURANCE CLAIM FORM  CHAMPVA GROUP FECA OTHER!: a INSURED'S LD NUMBER (FOR PROGRAM IN														
1 MEDICARE MEDICAID CHAMPUS CHAMPVA  (Medicare #) A (Medicaid #) (Sponsor's SSN) (VA File						GROUP HEALTH PLA (SSN or ID)	a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM :										
(Medicare #) A (Medicaid #) (Sponsor's SSN) (VA File 2 PATIENT'S NAME (Last Name, First Name, Middle Initial)								SSN, (ID,	123								
			initial)		3. P.	ATIENT'S BIRTH	Y	SEX	4. INSURED'S	NAME (	Last Na	me, First	Name.	Middle	initial)		
Recipient, 5. PATIENT'S ADDRESS (No.		•			- B	ATIENT RELATION	M	F X	- INCUPEDIO	<u> </u>	CC (N)						
609 Willow					!	elf Spouse			7. INSURED'S	ADDME	:55 (NO.	. Street)					
CITY WILLOW	v or.			CTATE		ATIENT STATUS		Offier	CITY							CTATE	
				WI	0.77		_		Cirr							STATE	
Anytown ZIP CODE	TELEPHON	NE (Incl)	Ma Area		4	Single	Married	Other	ZIP CODE			TELE	BUON	IE (INC)	LIDE AD		
	55555 (XXX) XXX – XXXX					mployed — Fu	ZIP CODE TELEPHONE (INCLUDE AREA CODE)								,		
9. OTHER INSURED'S NAM	1 \	,			10	St PATIENT'S CO	Udent	Student	11. INSURED'S	BOLIC	V GBOI	ID OD E	CA NI	/			
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a. OTHER INSURED'S POLI	CY OR GROUP N	VI IMBE	3		  a F	MPI OYMENT? ((	CHERENT	OR PREVIOUS)	a. INSURED'S	DATE	E BIDT	<u>.</u> .					
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b. OTHER INSURED'S DATE	OF BIRTH	SE		····	<b>Б</b> ДІ	UTO ACCIDENTS	1		b. EMPLOYER	SNAM	F OR SC	CHOOL N				<u></u>	
MM DD YY		-, 3E	^ F [	<del>-</del> -		YES	_	7no	D. Elmi Co I EA	O HAM	L On 30	JIIOOL II	AIVIL.				
c. EMPLOYER'S NAME OR S	SCHOOL NAME				6.0	THER ACCIDENT	L	<i>-</i> '	c. INSURANCE	PLAN	NAME C	R PROC	BALL A	VAME			
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d INSURANCE PLAN NAME	OR PROGRAM I	NAMF			10d	RESERVED FOR			d IS THERE AT	NOTHE	R HEAL	TH RENE	FIT D	AN?			
3. INSOLUTION FOR THE STATE OF								<del>-</del>	YES								
RE	AD BACK OF FO	ORM BE	FORE (	OMPLETING	G & SIG	GNING THIS FOI	RM.		13. INSURED'S	OP 41	NO ITHORIZ					em 9 a-d.	
12. PATIENT'S OR AUTHOR	RIZED PERSON'S	SIGNA	TURE I	authorize the	releas	e of any medical of	or other int		payment of	medical	benefits						or
to process this claim. I als below.	o request payment	t or gove	iruneni	penents enne	r to my:	sell or to the party	wno acce	pts assignment	services des	scribed	below.						
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MM DD YY INJURY (Acadent) OR						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM : DD : YY					YY	10 WOH	K IN C	MM	NI OCCU	YY	
7 NAME OF REFERRING F	PREGNANCY(L		SOURCE	17a	LD N	UMBER OF REF	EBBING	PHYSICIAN	FROM 18. HOSPITALI	ZATION	DATES	RELATE			NT SER	/ICES	
I.M. Refer						2345	271111110		FROM	DD	YY		TO.	MM	DD	YY	
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IS THE CENTED TO THE COOKE									_		I		J CHA	ndes	1		
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(I certify that the statement apply to this bill and are m	ts on the reverse						•			ъ.	<b></b> -						
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